FOR OHF USE

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043406

Facility Name: WOODSIDE EXTENDED CARE

Address: 120 WEST 26TH ST (Number) SO.CHICAGO HTS. (City) 60411 (Zip Code)

County: COOK

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

IDPA ID Number: 39-4153529

Date of Initial License for Current Owners: 11/01/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) MANAGER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	64	Skilled (SNF)	64	23,424	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,568	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	112	TOTALS	112	40,992	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,537	4,537	8
9	SNF/PED					9
10	ICF	35,780	106		35,886	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,780	106	4,537	40,423	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.61%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 4,422

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	133,216	11,363	11,340	155,919		155,919		155,919			1
2	Food Purchase		136,787		136,787		136,787	(705)	136,082			2
3	Housekeeping	97,704	11,773		109,477		109,477		109,477			3
4	Laundry	37,823	7,726	3,144	48,693		48,693	112	48,805			4
5	Heat and Other Utilities			118,016	118,016		118,016	278	118,294			5
6	Maintenance	68,927	16,030	24,972	109,929		109,929	(866)	109,063			6
7	Other (specify):* SECURITY/SCAVEN	47,512		6,169	53,681		53,681	50	53,731			7
8	**TOTAL General Services**	385,182	183,679	163,641	732,502		732,502	(1,131)	731,371			8
	B. Health Care and Programs											
9	Medical Director			9,750	9,750		9,750		9,750			9
10	Nursing and Medical Records	1,009,289	55,344	9,685	1,074,318		1,074,318		1,074,318			10
10a	Therapy	84,096			84,096		84,096		84,096			10a
11	Activities	58,477	8,925	2,480	69,882		69,882		69,882			11
12	Social Services	17,266		2,201	19,467		19,467		19,467			12
13	Nurse Aide Training											13
14	Program Transportation	5,529		7,206	12,735		12,735		12,735			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,174,657	64,269	31,322	1,270,248		1,270,248		1,270,248			16
	C. General Administration											
17	Administrative	84,494		279,000	363,494		363,494	(164,173)	199,321			17
18	Directors Fees											18
19	Professional Services			54,392	54,392		54,392	4,353	58,745			19
20	Dues, Fees, Subscriptions & Promotions			9,484	9,484		9,484	(382)	9,102			20
21	Clerical & General Office Expenses	77,207	14,738	110,475	202,420		202,420	(73,561)	128,859			21
22	Employee Benefits & Payroll Taxes			240,097	240,097		240,097		240,097			22
23	Inservice Training & Education			2,095	2,095		2,095	45	2,140			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			10,637	10,637		10,637	454	11,091			25
26	Insurance-Prop.Liab.Malpractice			59,125	59,125		59,125	497	59,622			26
27	Other (specify):*			342,000	342,000		342,000	(337,779)	4,221			27
28	**TOTAL General Administration**	161,701	14,738	1,107,305	1,283,744		1,283,744	(570,546)	713,198			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,721,540	262,686	1,302,268	3,286,494		3,286,494	(571,677)	2,714,817			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: WOODSIDE EXTENDED CARE **#0043406** **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	11,340	
	REPAIRS & MAINTENANCE		0	
			0	11,340
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,144	
			0	3,144
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		35,520	
	ELECTRICITY		44,800	
	WATER		36,928	
	CABLE TV - LOBBY		768	
			0	118,016
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,482	
	PAINTING & DECORATING		3,458	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		9,597	
	ELEVATOR MAINTENANCE & REPAIR		3,267	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,828	
	FIRE SERVICE		5,340	
			0	
			0	
			0	24,972
7	**OTHER**			
	SCAVENGER		6,043	
	SECURITY SERVICE		126	6,169
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	9,750	9,750

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	0	
	LABORATORY & XRAY EXPENSE		1,450	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	4,860	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL CONSULTANT	XVIII B 47-2	3,375	
			0	9,685
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,480	
			0	2,480
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	2,201	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	2,201
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WOODSIDE EXTENDED CARE **#0043406** **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		7,206	7,206
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	279,000	279,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	12,731	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	41,661	
			0	54,392
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	0	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	6,160	
	LICENSES & PERMITS	XIX F	2,307	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	117	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	400	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	9,484
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		231	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		42,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	90	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		15,968	
	MESSENGER SERVICE		0	
	STAFF DEVELOPMENT		52,186	110,475

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	130,423	
	UNEMPLOYMENT COMPENSATION	XIX D	25,409	
	WORKERS COMPENSATION INSURANCI	XIX D	55,744	
	HOSPITALIZATION INSURANCE	XIX D	26,168	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,353	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	240,097
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,095	2,095
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		10,637	10,637
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		59,125	59,125
27	**OTHER**			
	BAD DEBTS	VI 24	342,000	
				342,000

GRAND TOTAL COLUMN 3 OTHER 1,302,268

WOODSIDE EXTENDED CARE

EDUCATION & SEMINAR
12/31/04

ACCT #18180

	INV	SPONSOR OF SEMINAR	PURPOSE OF SEMINAR	PERSONNEL ATTENDING	DEPT	LOC	COST OF SEMINAR
FEB	X	ICLTC	NEW ENFORCEMENT OF SUBPART S	CLARA RICHARDSON		IL	380.00
				DEBBIE MASSEY	ADM		
				TRACY JOHNSON			
				GAIL ROBERTS			
MARCH	X	ICKTC	THE WITNESS STAND: EVERY NURSE'S NIGHTMARE	DEBBIE MASSEY	ADM	IL	190.00
				JANICE VILLASENOR	DON		
JUNE	X	ICLTC	G & P3: AFDL BASE AND RESTORATIVES	DEBBIE MASSEY	ADM	IL	190.00
				TIERRA CUEVAS	MS		
AUG	X	ICLTC	PSYCHOSOCIAL ADAPTION & REHABILITATION	DEBBIE MASSEY	ADM	IL	500.00
				CLARA RICHARDSON			
				GAIL ROBERTS			
				SUE BLOK			
OCT	X	ICLTC	SKILLED NURSING SERVICES & SPECIAL PATIENT NEEDS	DEBBIE MASSEY	ADM	IL	375.00
				TRUDI LOCKHART	CARE PLAN		
				GAIL ROBERTS			
NOV	X	ICLTC	SPECIAL SESSION FOR MDS & CARE PLAN COORD	TIERRA CUEVAS	MDS	IL	270.00
				DEBBIE MASSEY	ADM		
				TRUDI LOCKHARD	CARE PLAN		
DEC	X	ICLTC	THE NEW IDPH ALZHEIMER'S CARE CENTER REGULATION	DEBBIE MASSEY	ADM	IL	190.00
				MICHELLE EPPS	DON		
							2,095.00

EQUIPMENT RENTAL
COST REPORT 2004

KREG THERAPEUTIC	THERAPUTIC BED	1,125
PRO-CARE	THERAPUTIC BED	1,860
PI SURVEILLANCE	TV SECURITY MONITOR	9,000
GREAT AMERICA LEASING	COPIER	2,645
ILLINOIS BUSINESS SYSTEM	COPIER	1,823
MEIKEM	DISHWASHER	1,320
PITNEY BOWES	POSTAGE METER	930
PS ILLINOIS TRUST	STORAGE	1,665
		20,368

STAFF TRANSPORTATION
12/31/04

ACCT #18370

	NAME	DESCRIPTION	DEPARTMENT	AMOUNT
JAN	SEBASTIAN BUJAK	EMPLOYEE REIMBURSEMNT	PAINTERS	30.00
JAN	OLECH,STANISLAW	EMPLOYEE REIMBURSEMNT	PAINTERS	60.00
JAN	WITOLD REJENT	EMPLOYEE REIMBURSEMNT	PAINTERS	15.00
JAN	HENRYK STECHNIJ	EMPLOYEE REIMBURSEMNT	PAINTERS	15.00
MAR	PETTY CASH	GASOLINE	EMPLOYEE REIMBURSEMNT	30.00
APR	PETTY CASH	GASOLINE	EMPLOYEE REIMBURSEMNT	121.70
APR	DERRIL MACK			2,584.00
MAY	FLEET SERVICES	GASOLINE		2,045.62
MAY	PETTY CASH	GASOLINE	EMPLOYEE REIMBURSEMNT	180.65
JULY	PETTY CASH	GASOLINE	EMPLOYEE REIMBURSEMNT	168.80
AUG	SECRETARY OF STATE	LICENSE PLATE RENEWAL	MAINTENANCE	98.00
SEPT	PETTY CASH	GASOLINE	EMPLOYEE REIMBURSEMNT	246.50
DEC	PETTY CASH	GASOLINE	EMPLOYEE REIMBURSEMNT	159.40
DEC	FORD MOTOR	MILEAGE	MAINTENANCE	4,882.20
TOTAL				10,636.87

Facility Name & ID Number WOODSIDE EXTENDED CARE #0043406 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			218,368	218,368		218,368	(72,925)	145,443			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			158,047	158,047		158,047	(8,351)	149,696			32
33	Real Estate Taxes			148,969	148,969		148,969	1,194	150,163			33
34	Rent-Facility & Grounds			194,180	194,180		194,180		194,180			34
35	Rent-Equipment & Vehicles			33,575	33,575		33,575	3,251	36,826			35
36	Other (specify):* OFFICE RENT			8,736	8,736		8,736	(8,736)				36
37	**TOTAL Ownership**			761,875	761,875		761,875	(85,567)	676,308			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		96,738	198,484	295,222		295,222		295,222			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,488	61,488		61,488		61,488			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		96,738	259,972	356,710		356,710		356,710			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,721,540	359,424	2,324,115	4,405,079		4,405,079	(657,244)	3,747,835			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(73,943)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(705)	2		13
14	Non-Care Related Interest	(9,459)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(400)	20		17
18	Fines and Penalties	(90)	21		18
19	Entertainment				19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(342,000)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(117)	20		28
29	Other-Attach Schedule	(55,068)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (482,282)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(174,962)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (174,962)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (657,244)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

WOODSIDE EXTENDED CARE

ID# 0043406

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ -2882	6	1
2	STAFF DEVELOPMENT	(52,186)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(55,068)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(705)	0	0	0	0	0	0	0	0	0	0	(705)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	112	0	0	0	0	0	0	0	0	0	112	4
5	Heat and Other Utilities	0	0	278	0	0	0	0	0	0	0	0	278	5
6	Maintenance	(2,882)	1,312	704	0	0	0	0	0	0	0	0	(866)	6
7	Other (specify):*	0	20	30	0	0	0	0	0	0	0	0	50	7
8	**TOTAL General Services**	(3,587)	1,444	1,012	0	0	0	0	0	0	0	0	(1,131)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	4,342	(168,515)	0	0	0	0	0	0	0	0	(164,173)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,207	146	0	0	0	0	0	0	0	0	4,353	19
20	Fees, Subscriptions & Promotions	(1,017)	635	0	0	0	0	0	0	0	0	0	(382)	20
21	Clerical & General Office Expenses	(52,276)	(26,357)	5,072	0	0	0	0	0	0	0	0	(73,561)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	45	0	0	0	0	0	0	0	0	0	45	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	311	143	0	0	0	0	0	0	0	0	454	25
26	Insurance-Prop.Liab.Malpractice	0	207	290	0	0	0	0	0	0	0	0	497	26
27	Other (specify):*	(342,000)	2,806	1,415	0	0	0	0	0	0	0	0	(337,779)	27
28	**TOTAL General Administration**	(395,293)	(13,804)	(161,449)	0	0	0	0	0	0	0	0	(570,546)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(398,880)	(12,360)	(160,437)	0	0	0	0	0	0	0	0	(571,677)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(73,943)	166	852	0	0	0	0	0	0	0	0	(72,925)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,459)	0	1,108	0	0	0	0	0	0	0	0	(8,351)	32
33	Real Estate Taxes	0	0	1,194	0	0	0	0	0	0	0	0	1,194	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	2,755	496	0	0	0	0	0	0	0	0	3,251	35
36	Other (specify):*	0	0	(8,736)	0	0	0	0	0	0	0	0	(8,736)	36
37	**TOTAL Ownership**	(83,402)	2,921	(5,086)	0	0	0	0	0	0	0	0	(85,567)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(482,282)	(9,439)	(165,523)	0	0	0	0	0	0	0	0	(657,244)	45

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				EKS MGMT	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSULT
SEE ATTACHED SCHEDULES				IME REALTY	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	MAINTENANCE	$	EKS MANAGEMENT		$ 1,312	$ 1,312	1
2	V	7	SCAVENGER		" "		20	20	2
3	V	17	CFO SALARY		" "		4,342	4,342	3
4	V	19	PROFESSIONAL FEES		" "		4,207	4,207	4
5	V	20	WANT ADS		" "		635	635	5
6	V	21	CLERICAL	42,000	" "		15,643	(26,357)	6
7	V	23	SEMINARS		" "		45	45	7
8	V	25	STAFF TRANSPORTATION		" "		311	311	8
9	V	26	INSURANCE		" "		207	207	9
10	V	27	EMPLOYEE BENEFITS		" "		2,806	2,806	10
11	V	30	SL DEPRECIATION		" "		166	166	11
12	V	35	EQUIPMENT RENT		" "		2,755	2,755	12
13	V	4	HOUSEKEEPING		" "		112	112	13
14	Total			$ 42,000			$ 32,561	$ * (9,439)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 177,000	EMI ENTERPRISES		$	$ (177,000)	15
16	V	17	OFFICERS SALARY		" "		8,485	8,485	16
17	V	19	ACCOUNTING FEES		" "		102	102	17
18	V	21	CLERICAL		" "		4,949	4,949	18
19	V	25	STAFF TRANSPORTATION		" "		143	143	19
20	V	26	INSURANCE		" "		144	144	20
21	V	27	EMPLOYEE BENEFITS		" "		1,415	1,415	21
22	V	35	AUTO LEASE		" "		412	412	22
23	V								23
24	V								24
25	V	36	OFFICE RENT	8,736	IME REALTY			(8,736)	25
26	V	5	UTILITIES		" "		278	278	26
27	V	6	REPAIRS/MAINTENANCE		" "		704	704	27
28	V	19	PROFESSIONAL FEES		" "		44	44	28
29	V	21	OFFICE EXPENSE		" "		123	123	29
30	V	26	INSURANCE		" "		146	146	30
31	V	30	SL DEPRECIATION		" "		852	852	31
32	V	32	INTEREST		" "		1,108	1,108	32
33	V	33	REAL ESTATE TAX		" "		1,194	1,194	33
34	V	35	STORAGE FEES		" "		84	84	34
35	V	7	ALARM SERVICE		" "		30	30	35
36	V								36
37	V								37
38	V								38
39	Total			$ 185,736			$ 20,213	$ * (165,523)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ALLOCATION FROM EMI ENTERPRISES:				SEE ATTACHED				$		1
2	MORRIS ESFORMES	PRESIDENT	MGMT CONSULT	40.00	SCHEDULE	5	7.00	SALARY	8,485	17-7	2
3											3
4											4
5	PHILIP ESFORMES	MGMT CONSULT	MGMT CONSULT	22.50		5	8.00	MGMT FEE	102,000	17-3	5
6											6
7											7
8	ALLOCATION FROM EKS MANAGEMENT:										8
9	AVRUM WEINFELD		CFO			3	6.00	SALARY	4,342	17-7	9
10											10
11											11
12											12
13								TOTAL	$ 114,827		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT
Street Address: 6865 N LINCOLN
City / State / Zip Code: LINCOLNWOOD IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE	CENSUS DAYS	881,303	14 FACILITIES	$ 28,615	$ 28,615	40,423	$ 1,312	1
2	7	SCAVENGER	" "	881,303	14 FACILITIES	429		40,423	20	2
3	17	CFO SALARY	" "	881,303	14 FACILITIES	94,671	94,671	40,423	4,342	3
4	19	PROFESSIONAL FEES	" "	881,303	14 FACILITIES	91,723	65,670	40,423	4,207	4
5	20	WANT ADS	" "	881,303	14 FACILITIES	13,841		40,423	635	5
6	21	CLERICAL	" "	881,303	14 FACILITIES	341,059	251,740	40,423	15,643	6
7	23	SEMINARS	" "	881,303	14 FACILITIES	984		40,423	45	7
8	25	STAFF TRANSPORTATION	" "	881,303	14 FACILITIES	6,783		40,423	311	8
9	26	INSURANCE	" "	881,303	14 FACILITIES	4,521		40,423	207	9
10	27	EMPLOYEE BENEFITS	" "	881,303	14 FACILITIES	61,166		40,423	2,806	10
11	30	SL DEPRECIATION	" "	881,303	14 FACILITIES	3,617		40,423	166	11
12	35	EQUIPMENT RENT	" "	881,303	14 FACILITIES	60,061		40,423	2,755	12
13	4	HOUSEKEEPING	" "	881,303	14 FACILITIES	2,437	2,437	40,423	112	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 709,907	$ 443,133		$ 32,561	25

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES
Street Address: 6865 N LINCOLN
City / State / Zip Code: LINCOLNWOOD IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	CENSUS DAYS	881,303	14 FACILITIES	$ 185,000	$ 185,000	40,423	$ 8,485	1
2	19	ACCOUNTING FEES	" "	881,303	14 FACILITIES	2,230		40,423	102	2
3	21	CLERICAL	" "	881,303	14 FACILITIES	107,899	87,197	40,423	4,949	3
4	25	STAFF TRANSPORTATION	" "	881,303	14 FACILITIES	3,109		40,423	143	4
5	26	INSURANCE	" "	881,303	14 FACILITIES	3,139		40,423	144	5
6	27	EMPLOYEE BENEFITS	" "	881,303	14 FACILITIES	30,842		40,423	1,415	6
7	35	AUTO LEASE	" "	881,303	14 FACILITIES	8,991		40,423	412	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 341,210	$ 272,197		$ 15,650	25

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY
Street Address: 6865 N LINCOLN
City / State / Zip Code: LINCOLNWOOD IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	182,825	15 + FACIL	$ 5,821	$	8,736	$ 278	1
2	6	REPAIRS/MAINTENANCE	" "	182,825	15 + FACIL	14,726		8,736	704	2
3	19	PROFESSIONAL FEES	" "	182,825	15 + FACIL	922		8,736	44	3
4	21	OFFICE EXPENSE	" "	182,825	15 + FACIL	2,569		8,736	123	4
5	26	INSURANCE	" "	182,825	15 + FACIL	3,059		8,736	146	5
6	30	SL DEPRECIATION	" "	182,825	15 + FACIL	17,825		8,736	852	6
7	32	INTEREST	" "	182,825	15 + FACIL	23,196		8,736	1,108	7
8	33	REAL ESTATE TAX	" "	182,825	15 + FACIL	24,982		8,736	1,194	8
9	35	STORAGE FEES	" "	182,825	15 + FACIL	1,763		8,736	84	9
10	7	ALARM FEES	" "	182,825	15 + FACIL	618		8,736	30	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 95,481	$		$ 4,563	25

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1			X	MORTGAGE		04/04	$ 4,588,000	$ 4,553,547	04/09		$ 133,004	1
2	LOAN COSTS		X	AMORTIZE OVER LIFE OF LOAN		04/04	35,360	30,645	04/09		4,715	2
3												3
4												4
5	RELATED PARTY: IME REALTY		X	MORTGAGE							1,108	5
	Working Capital											
6	MB FINANCIAL		X	WORKING CAPITAL						PRIME+	35	6
7	US BANK		X	WORKING CAPITAL-LOC				207,000		PRIME+	1,923	7
8	CIB BANK		X	WORKING CAPITAL				310,000		PRIME+	18,370	8
9	TOTAL Facility Related						$ 4,623,360	$ 5,101,192			$ 159,155	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,623,360	$ 5,101,192			$ 159,155	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	255,620	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	233,772	2
3. Under or (over) accrual (line 2 minus line 1).	$	(21,848)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	236,110	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 65,293 For 99-01 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$	(65,293)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	148,969	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999	226,504	8
2000	232,727	9
2001	245,999	10
2002	253,088	11
2003	233,772	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

LINE 6 REFUND 1999=21964, 2000=21553, 2001=21776 / LEGAL EXPENSE 21547

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WOODSIDE EXTENDED CARE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0043406

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	32-29-401-011-0000	NURSING HOME	$ 233,772.24	$ 233,772.24
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 233,772.24	$ 233,772.24

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,900 B. General Construction Type: Exterior CONCRETE Frame METAL/CONCRETE Number of Stories 1 + BASEMENT

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		2004	$ 229,826	1
2					2
3	TOTALS			$ 229,826	3

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	112		2004		$ 4,142,702	$ 106,716	27.5	$ 106,716	$	$ 106,716	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CEILING LIGHTING			1997	3,746	96	39	96		684	9
10	WATER SOFTENING SYSTEM			1997	6,926	178	39	178		1,268	10
11	FLOORING			1997	3,910	100	39	100		704	11
12	FLOORING / DOORS / WINDOWS			1998	29,194	748	39	748		4,962	12
13	ROOF			1998	84,450	2,165	39	2,165		14,888	13
14	DUMBWAITER/FAUCETS/CABINETS/WALLPAP./CUB.CURT.			1998	30,915	793	39	793		5,462	14
15	PAINTING / DECORATING			1998	15,111	387	39	387		2,532	15
16	FLOORING / DOORS / BATHROOM FIXTURES			1999	11,198	288	39	288		1,708	16
17	CHAIN LINK FENCE			1999	5,100	131	39	131		715	17
18	FLOOR TILES/COVE BASE			2000	22,766	828	27.5	828		4,105	18
19	PAIR OF ALUMINUM DOORS			2000	2,193	80	27.5	80		383	19
20	PLUMBING			2000	9,913	360	27.5	360		1,485	20
21	PLUMBING / VANITY / SINK / FLOORING			2001	37,788	1,374	27.5	1,374		5,124	21
22	DRAPERIES			2001	7,578	873	10	758	(115)	2,653	22
23	PAVING			2002	18,562	675	27.5	675		1,716	23
24	BATHROOM SINKS			2002	3,888	141	27.5	141		288	24
25	BATHROOM SINKS			2003	7,776	283	27.5	283		554	25
26	FLOORING / CARPETING & TILE			2003	13,887	504	27.5	504		621	26
27	ROOF			2003	7,800	284	27.5	284		461	27
28	FENCE			2003	9,500	634	15	634		950	28
29	WINDOWS			2004	46,880	1,066	27.5	1,066		1,066	29
30	CUBICLE CURTAINS/FLOORING			2004	33,108	19,865	10	1,655	(18,210)	1,655	30
31											31
32											32
33											33
34	RELATED PARTY ALLOCATION - IME REALTY					819		819			34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,554,891	$ 139,388		$ 121,063	$ (18,325)	$ 160,700	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 144,338	$ 14,620	$ 11,762	$ (2,858)	8-15 YRS	$ 61,534	71
72	Current Year Purchases	224,000	65,179	12,419	(52,760)	8-15 YRS	12,419	72
73	Fully Depreciated Assets							73
74	RELATED PARTY ALLOC - EKS MGMT 166/IME REALTY 33		199	199				74
75	TOTALS	$ 368,338	$ 79,998	$ 24,380	$ (55,618)		$ 73,953	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,153,055	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 219,386	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 145,443	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (73,943)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 234,653	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: MAJ ENTERPRISES INC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		112	11/98	$ 194,180	19		3
4	Additions							4
5		FACILITY PURCHASED 4/15/04						5
6								6
7	TOTAL		112		$ 194,180 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 11/01/1998
Ending 10/31/2017

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$ 594,463
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 20,368 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE:	'01 CHEVY WAGON	$ 699.24	$ 1,784	17
18	BANKING,MAINT,	'04 FORD PICKUP	575.00	3,518	18
19	MARKETING, NSG,	'03 FORD ECOLINE WAGON	658.77	7,905	19
20	ACTIVITIES				20
21	TOTAL		$ #######	$ 13,207	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 97,809	$		$ 97,809	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			715			715	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			99,960			99,960	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				92,407		92,407	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): RADIOLOGY/LAB	39-2					4,331		4,331	13
14	TOTAL			$		$ 198,484	$ 96,738		$ 295,222	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 70,055	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 200,000)	1,099,339		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,475		6
7	Other Prepaid Expenses	50,063		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): R.E.TAX ESCROW	218,667		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,472,599	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	229,826		13
14	Buildings, at Historical Cost	4,142,702		14
15	Leasehold Improvements, at Historical Cost	404,611		15
16	Equipment, at Historical Cost	409,879		16
17	Accumulated Depreciation (book methods)	(376,980)		17
18	Deferred Charges	30,645		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,840,683	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,313,282	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 161,627	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,320		28
29	Short-Term Notes Payable	579,921		29
30	Accrued Salaries Payable	63,608		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,261		31
32	Accrued Real Estate Taxes(Sch.IX-B)	236,110		32
33	Accrued Interest Payable	20,067		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MEMBERS' LOANS	465,723		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,559,637	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,490,626		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,490,626	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,050,263	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 263,019	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,313,282	$	48

*(See instructions.)

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 240,106	1
2	Restatements (describe):		2
3			3
4	ROUNDING	4	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 240,110	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	513,909	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(491,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 22,909	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 263,019	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,848,119	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,848,119	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	71,056	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 71,056	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,459	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,459	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,928,634	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	732,502	31
32	Health Care	1,270,248	32
33	General Administration	1,283,744	33
	B. Capital Expense		
34	Ownership	761,875	34
	C. Ancillary Expense		
35	Special Cost Centers	295,222	35
36	Provider Participation Fee	61,488	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,405,079	40
41	**Income before Income Taxes (line 30 minus line 40)****	523,555	41
42	**Income Taxes**	(9,646)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 513,909	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,743	1,830	$ 47,324	$ 25.86	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,159	4,226	81,385	19.26	3
4	Licensed Practical Nurses	14,659	14,902	262,956	17.65	4
5	Nurse Aides & Orderlies	56,222	60,109	486,062	8.09	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,684	6,159	84,096	13.65	8
9	Activity Director					9
10	Activity Assistants	7,434	7,886	58,477	7.42	10
11	Social Service Workers	2,007	2,150	17,266	8.03	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,925	17,050	133,216	7.81	15
16	Dishwashers					16
17	Maintenance Workers	7,880	8,026	68,927	8.59	17
18	Housekeepers	13,508	14,181	97,704	6.89	18
19	Laundry	5,462	5,763	37,823	6.56	19
20	Administrator	2,133	2,156	84,494	39.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,572	8,088	77,207	9.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,776	1,903	13,797	7.25	31
32	Other Health C: MDS/TRANSPOR	9,103	5,406	123,294	22.81	32
33	Other(specify) SECURITY	6,024	6,176	47,512	7.69	33
34	TOTAL (lines 1 - 33)	161,291	166,011	$ 1,721,540 *	$ 10.37	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 11,340	1-3	35
36	Medical Director	O	9,750	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	4,860	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,480	11-3	44
45	Social Service Consultant	E	2,201	12-3	45
46	Other(specify)	S			46
47	DENTAL CONSULTANT		3,375	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 34,006		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DEBBIE MASSEY	ADMIN		$ 84,494
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 84,494

B. Administrative - Other

Description	Amount
EMI ENTERPRISES	$ 177,000
PHILIP ESFORMES	102,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 279,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA		$ 3,993
HDSI		5,549
LTC SOLUTION		1,320
MAXX SOURCE		1,345
MUTUAL OF OMAHA		524
KBKB		11,100
HOLLAND & KNIGHT		1,254
SACHNOFF & WEAVER		240
STONE MCGUIRE & BENJAMIN		2,120
KLAFTER & BURKE		21,547
PERSONNEL PLANNERS		900
RICHARD PEELO		4,500
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 54,392

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 55,744
Unemployment Compensation Insurance		25,409
FICA Taxes		130,423
Employee Health Insurance		26,168
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		2,353
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 240,097

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	0
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	117
TRUST/FRANCHISE/CONTRIB/ETC	900
LICENSES & PERMITS	2,307
DUES & SUBSCRIPTIONS	6,160
MGMT CO ALLOCATION	635
TRUST/FRANCHISE/CONTRIB/ETC	(900)
Less: Public Relations Expense	(0)
Non-allowable advertising	(0)
Yellow page advertising	(117)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,102

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING/DÉCORAT'C	2004	$ 3,458	3	$	$	$	$ 576	$ 1,153	$ 1,153	$ 576	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 3,458		$	$	$	$ 576	$ 1,153	$ 1,153	$ 576	$	$

Facility Name & ID Number WOODSIDE EXTENDED CARE # 0043406 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $ 6,160**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **61,488**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees